RULES
OF
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF INSURANCE ADMINISTRATION

CHAPTER 0620-5-1
COVER KIDS RULES

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0620-5-1-.01 DEFINITIONS.

(1) Unless otherwise specifically defined in these rules, these terms will have the following meaning:

(a) "Administrative Contractor" or "AC" is the entity responsible for determining eligibility of applicants to CoverKids. This may be a private contractor, government agency, or Departmental entity.

(b) "Budget Group" means for each applicant, the following family members living with the applicant: the applicant's spouse, the applicant's minor unmarried children, the siblings of children in the home when the applicant child and siblings do not have income of their own, and each of the applicant's financially responsible adults as indicated by the family including natural, adoptive, and step-parents. Children with SSI or Families First are not included in a budget group.

(c) "Commissioner" is the executive officer in charge of the Tennessee Department of Finance and Administration.

(d) "Commissioner's Designee" means a person or group of persons appointed by the Commissioner to perform a particular function under these rules.

(e) "CoverKids" is the program created by Tennessee Code Annotated Section 71-3-1101 et seq. and includes its authorized employees and agents as the context of the rules requires.

(f) "Days" means calendar days rather than business days.

(g) "Meaningful Access" is insurance coverage that includes a network of providers within a reasonable distance from the area in which the covered individual lives.

(h) "Parent" means a natural or appointed guardian of minor children as defined by Title 34, Part 1 of Tennessee Code Annotated subject to court orders entered or recognized by the courts of the state of Tennessee.

(i) "Plan Administrator" or "PA" is the entity responsible for providing health care services to CoverKids enrollees. This may be a private contractor, government agency, or Departmental entity.

(Rule 0620-5-1-.01, continued)

(j) "PE Entity" or "FTE Entity" refers to Cover Kids Contractors or designated providers authorized by CoverKids to determine that a newborn baby or pregnant woman is eligible for CoverKids under the presumptive eligibility or fast track eligibility rules and procedures.

(k) "SSI" means Supplemental Security Income benefits provided by the Social Security Administration.

Authority: *T.C.A. §§ 4-5-202, 71-3-1106. 71-3-1110.* ***Administrative History:*** *Public necessity rule filed March 13, 2007; expired August 25, 2007. Original rule filed May 30, 2007; effective August 13, 2007. Amendment filed May 22, 2008; effective August 5, 2008.*

0620-5-1-.02 ELIGIBILITY.

(1) Citizenship.

(a) Children must be citizens of the United States or persons designated as qualified aliens under 8 U.S.C. 1642 as applied to programs under Title XXI of the Social Security Act by federal law including 42 C.F.R. 457.320(b)(6). Notwithstanding any language to the contrary, CoverKids will grant eligibility to an unborn child whose mother is either an undocumented alien or a permanent resident alien who has not resided in the United States in that status for at least five years, to the extent that such coverage is mandated by the United States Department of Health and Human Services.

(b) CoverKids will comply with applicable amendments to Federal laws and regulations concerning eligibility of non-citizens.

(2) Residency.

(a) The applicant must be a resident of the state of Tennessee.

(3) Social Security Number.

(a) All applicants must have a Social Security Number (SSN) or proof of application for a SSN. For newborns less than 4 months of age an application for an SSN must be filed. SSN are not required for parents and children not applying for CoverKids coverage.

(b) Families with children under 4 months of age who were approved for CoverKids coverage without an SSN should submit the SSN to the AC as soon as received. A SSN must be received by redetermination.

(4) Age.

(a) Applicants must be either a child under 19 years of age or a pregnant woman. CoverKids coverage for children ends the last day of the month in which the child turns 19.

(b) A female that that become pregnant at 18 years of age with a delivery date that occurs after her 19th birthday, will be allowed to retain coverage so as not to create discontinuity of care for prenatal, delivery, and post-partum care. This coverage will continue until the end of the month in which the 60th postpartum day occurs. All services rendered would be related to post-pregnancy care.

(Rule 0620-5-1-.02, continued)

(c) Information of the child's age on the CoverKids application is sufficient verification of age. Any applicant for whom a date of birth is not provided will be denied CoverKids coverage.

(5) Insurance Coverage.

(a) Factors in Determining Current Insurance Coverage.

1. The applicant must not be currently covered under a comprehensive health insurance policy for either individual, group or employer-based insurance, or

2. The applicant must not have had comprehensive individual, group or employer-based health insurance in the past three months, including Medicare, with exception allowed for non-voluntary loss of insurance. Applicants will not be eligible for coverage any earlier than the fourth month after the private coverage ends.

3. Specialty insurance coverage, such as dental-only or catastrophic-only coverage, is not considered comprehensive health insurance.

4. Coverage through the State of Tennessee's Children's Special Services (CSS) program is not to be considered comprehensive health insurance for eligibility purposes.

5. Information on the CoverKids application is sufficient verification of an applicant being uninsured. The State reserves the right to investigate the insurance status of applicants. If the State determines that the applicant has other insurance or has not been without comprehensive health insurance for at least three (3) months, the State has the right to cancel coverage. The CoverKids application must be submitted with a copy of the front and back side of the insurance card for any applicants who indicate there is other insurance coverage.

(b) If the applicant is a pregnant woman with individual, group or employer based health insurance, she may be enrolled in CoverKids if her insurance does not cover prenatal/maternity care. The AC will use the information on the application, the copy of the insurance card and information obtained by contacting the insurance company to determine if prenatal/maternity care is covered by the private insurance.

(6) Assets.

(a) No asset test is used.

(7) Income

(a) To be eligible for CoverKids, children and pregnant women must have adjusted gross income above TennCare Medicaid levels but at or below 250% of the Federal Poverty Level. CoverKids may enroll persons above 250% of the Federal Poverty Level under the terms and conditions set forth in these Rules. This program will use the limited self declared information on the application to screen each applicant for potential TennCare Medicaid eligibility by aligning with the guidelines currently used in the Department of Human Services for determination of both budget groups and income calculation to the extent possible. Final determination of TennCare eligibility will be determined by the

(Rule 0620-5-1-.02, continued)

Department of Human Services or TennCare. These guidelines are subject to change with changes to the Department of Human Services guidelines. Further, these guidelines are for TennCare screening purposes only and are subject to change in accordance with any mandatory regulations issued from the federal level.

(b) The CoverKids application will request income information for adults who are parents (biological, adopted or step) and for caretaker relatives who are caring for children when neither parent lives in the home or in the event a parent lives in the house but the parent's current circumstances or conditions necessitate that a caretaker relative is the responsible adult assuming care of that child.

(c) All family income of the budget group must be reported on the application. Self-declaration of income by the responsible adult(s) of the applicant or the applicant is sufficient verification and must include the payee's name and the gross amount of monthly income.

(d) The financial eligibility for CoverKids will be calculated as follows:

1. Depending on family relationships, a family may be comprised of one or multiple budget groups.

2. If a child receives income and is applying for coverage, then that child and his income must be counted in the budget group.

3. If a pregnant female is under the age of 19 and lives in the household with her parents, the pregnant female's budget group would consist of the pregnant minor and her parents.

(e) Countable Income.

1. Self-declaration of income is allowed for applicants using the CoverKids application.

2. Income must be reported as a monthly amount.

(f) Financial Factors - The AC will calculate each budget group's adjusted gross income for the month that eligibility will begin based on recent income information provided by the family on the CoverKids application. Adjusted gross income is the sum of all countable income for persons in the budget group.

(8) Non-factors.

(a) The following must not be a factor in determining CoverKids eligibility:

1. Disability status.

2. Pre-existing condition.

3. Diagnosis.

(9) Excluded Children.

(a) Individuals who are not eligible for CoverKids include children who:

(Rule 0620-5-1-.02, continued)

1. Are eligible for TennCare Medicaid.

2. Are enrolled in TennCare Medicaid or TennCare Standard.

3. Have been criminally adjudicated and are in a correctional facility, including a detention home or training school.

4. Are admitted to an institution for mental disease.

5. Are eligible for health insurance coverage on the basis of a responsible adult's (self, parent, spouse, etc.) employment by a state or local education agency.

6. Have had comprehensive individual, group or employer-based health insurance in the past three months and voluntarily discontinued the comprehensive insurance, regardless of the cost.

(b) When the AC is made aware that any CoverKids beneficiary meets one of the conditions above, the AC will contact the family to verify the information received (if not received from family) and if verified, will disenroll beneficiaries from CoverKids. The AC will send a termination letter to the families. Disenrollment and Review shall be conducted under the procedures set forth in rule 0620-5-1-.04 and 0620-5-1-.05 of these rules.

(10) Updated Federal Poverty Levels.

(a) Upon release by the federal government of a new calendar year's Federal Poverty Levels (usually in late winter), the AC will update the eligibility database to reflect the update.

(11) Fast Track Eligibility (FTE). The State reserves the right to discontinue the Fast Track Eligibility Process should a significant number of incorrect determinations be made.

(a) Fast Track Eligibility for Pregnant Women (FTE-PW)-CoverKids Healthy Babies Program allows a pregnant woman to have immediate CoverKids coverage that begins on the day of the visit to a FTE entity as long as a complete, signed CoverKids application is submitted and all FTE requirements are met. The eligibility begins on date of signed application. To be eligible for FTE-PW, the applicant must:

1. Live in a family with adjusted gross income, as reported to the FTE entity, which is at or below 250% FPL.

2. Work with the FTE entity to submit a complete, signed CoverKids application.

3. Not have had FTE-PW within the last 18 months.

4. Not be currently enrolled in TennCare or CoverKids.

5. Not be currently enrolled in comprehensive health insurance coverage. (If a pregnant woman has health insurance that does not cover prenatal/delivery services, she will not be considered to have comprehensive health insurance coverage.)

(Rule 0620-5-1-.02, continued)

6. Not have been enrolled in comprehensive health insurance coverage that was voluntarily terminated at any time within the three months prior to the visit with the FTE entity. (If a pregnant woman had health insurance that did not cover prenatal/delivery services, she will not be considered to have had comprehensive health insurance coverage.)

7. Not have access to state administered health insurance by means of a family member's employment with a state or local education agency.

(b) Fast Track Eligibility for Newborns (FTE-NB) allows a newborn to have immediate CoverKids coverage that begins on the day of the visit to a FTE entity as long as a complete, signed CoverKids application is submitted and all FTE requirements are met. The eligibility begins on date of signed application which will also be the date the FTE entity makes the FTE determination. To be eligible for FTE-NB, the applicant must:

1. Be a newborn who is not yet 4 months old.

2. Be a citizen or, as defined in federal law, an eligible immigrant.

3. Live in a family with adjusted gross income, as reported to the FTE entity, which is above 185% FPL and below 250% FPL.

4. Work with the FTE entity to submit a complete, signed CoverKids application.

5. Not have had FTE-NB within the last 18 months.

6. Not be currently enrolled in TennCare or CoverKids.

7. Not be currently enrolled in comprehensive health insurance coverage.

8. Not have been enrolled in comprehensive health insurance coverage that was voluntarily terminated at any time within the three months prior to the visit with the FTE entity.

9. Not have access to state administered health insurance by means of a family member's employment with a state or local education agency.

(c) Fast Track Eligibility For Children (FTE-C) Transitioning from TennCare allows certain children whose TennCare coverage is ending to have immediate CoverKids coverage that begins on the day TennCare ends as long as all PE-C requirements are met. This effort is to ensure that there are no gaps in coverage. To be eligible for CoverKids PE-C, the child must:

1. Be under 19 years of age.

2. Be a child for whom a TennCare final termination has or will be issued.

3. Not be currently enrolled in CoverKids.

4. Not be currently enrolled in comprehensive health insurance coverage.

5. Have adjusted gross family income greater than the TennCare level for which they were enrolled and at or less than 250% of the FPL. This income information for the purpose of CoverKids enrollment will be self-

(Rule 0620-5-1-.02, continued)

declared on the CoverKids application. Income information may not be older than forty-five (45) days old.

6. Families should apply before termination of the TennCare coverage to allow for no gaps in coverage. However, families must submit a complete CoverKids application within thirty (30) days before TennCare termination to be considered for CoverKids coverage beginning the day after TennCare coverage ends.

(12) Changes in Family Status. If the family has applied for CoverKids and coverage was denied, applicants may reapply for CoverKids any time a change occurs that may make them eligible. This could include a change in family size, pregnancy, loss of a job, or change in family income. (A change in the child's health status does not make a child eligible for CoverKids.) If a family has a change in status that makes the children newly eligible for CoverKids, the family should reapply as soon as possible.

(13) Annual Redetermination of Eligibility.

(a) Eligibility determinations will be done annually. The AC will mail a CoverKids redetermination form to families within 60 calendar days of the beneficiary's last day of continuous eligibility. The family must review the renewal letter, note changes, attach documentation as appropriate, sign it and return it to AC. The AC will make an eligibility determination for each applicant on the redetermination form. The AC may present an option of renewal online.

(b) For beneficiaries at or above 250% of the FPL who continue to be otherwise eligible in this category, CoverKids eligibility will continue as long as the family continues to pay premiums timely each month.

(14) Pregnant women with income above 250% of the Federal poverty level will only be eligible for CoverKids enrollment if they are presently enrolled in the CoverTN program or presently enrolled in the CoverKids program.

(15) Enrollment Caps.

(a) Enrollment of children with income (as previously defined in this regulation) at or less than 250% of the Federal Poverty Limit is dependent on federal funding under the SCHIP program authorized in Title XXI of the Social Security Act, and may be limited by Federal laws and regulations governing the SCHIP program and the funding allocated to the state of Tennessee

(b) Enrollment of children with income greater than the 250% of the Federal Poverty Limit may be subject to enrollment caps at the discretion of CoverKids management, if CoverKids management determines that enrollment caps are required to preserve the financial stability of the program or that continued enrollment of these applicants creates risk of expenditures for the overall program exceeding appropriations.

(c) Enrollment of pregnant women over 250% of the Federal Poverty Limit is limited to pregnant women already enrolled and in good standing with the CoverKids program and women already enrolled in CoverTN.

Authority: *T.C.A. §§ 4-5-202, 71-3-1106. 71-3-1110.* ***Administrative History:*** *Public necessity rule filed March 13, 2007; expired August 25, 2007. Original rule filed May 30, 2007; effective*

(Rule 0620-5-1-.02, continued)

August 13, 2007. Public necessity rule filed February 22, 2008; effective through August 5, 2008. Amendments filed May 22, 2008; effective August 5, 2008.

0620-5-1-.03 COST SHARING—PREMIUMS AND CO-PAYS.

(1) Premiums.

(a) CoverKids enrollees in families with income equal to or less than 250% of the Federal Poverty Limit will not be assessed premiums.

(b) CoverKids enrollees in families with income greater than 250% of the Federal Poverty Limit will be assessed a monthly full premium for each beneficiary. The enrollee family is responsible for payment of the premium each month.

(c) The premium will be determined by the State's insurance plan administrator based on its determination of historical costs and estimates of future costs over the life of the contract. This determination will be reviewed by CoverKids and will be posted on the website of the insurance plan administration. The website address and cost information will be distributed to the public by CoverKids.

(d) Payment of the first month's premium will be required for services to begin.

(e) Pregnant women with income greater than 250% of the Federal Poverty level shall pay a lump sum in advance for maternity related services only if she is presently enrolled in CoverKids program.

(2) Failure to Pay Premiums.

(a) If the enrollee is delinquent in paying premiums and fails to pay the appropriate premiums within 31 days of the due date of the premium, the enrollee will be considered delinquent and may be subject to disenrollment from CoverKids.

(b) When an enrollee is delinquent in paying a premium, the health plan will notify the family, in writing, of:

1. The amount due.

2. The date the past due premium must be paid.

3. The disenrollment from the health plan if the past due premium is not paid.

4. The date coverage will end.

5. The need to report any change in circumstances (for example: loss of income, additional family members, or requirement to pay child support for a child not living with the family) which may result in a new determination of eligibility.

6. The right to request a health plan review and a Department Review and the procedures to follow in requesting a review.

(c) A delinquency notice will be issued on the day that the payment is due if payment has not been received. A termination notice will issue if the payment is not received within 31 days of the due date.

(Rule 0620-5-1-.03, continued)

(d) All reviews will be conducted according to the procedures in rule 0620-5-1-.05.

(e) Once disenrolled from CoverKids for failure to pay required premiums, applicants will not be eligible for CoverKids coverage until payment for unpaid amounts is made and for six (6) months after the disenrollment for nonpayment of premiums. In these cases, a new CoverKids application must be submitted. Applications received within one month of the month that follows the six month period will be accepted. Coverage will not begin before the first month's premium and all previously unpaid premium amounts have been paid.

(3) Co-Pays.

(a) CoverKids will assess co-pays for certain covered services as detailed in the chart attached as follows:

BENEFIT	FAMILY INCOME BETWEEN 150-250% FPL	FAMILY INCOME AT OR BELOW 150% FPL
Annual Deductible	None	None
Preexisting Condition Requirement	None	None
Physician Office Visit	$15 copay PCP; $20 copay specialist	$5 copay PCP or specialist
Hospital Care	$100 per admission (waived if readmitted within 48 hours for same episode)	$5 per admission (waived if readmitted within 48 hours for same episode)
Prescription Drug Coinsurance/Copay	$5 generic; $20 preferred brand; $40 non-preferred brand	$1 generic; $3 preferred brand; $5 non-preferred brand
Maternity	$15 copay OB, first visit only; $20 copay specialist; $100 hospital admission	$5 copay OB or specialist, first visit only; $5 hospital admission
Routine Health Assessment and Immunizations – Child	No copays for services rendered under American Academy of Pediatrics guidelines	No copays for services rendered under American Academy of Pediatrics guidelines
Emergency Room	$50 copay per use	$5 copay per use in case of an

(Rule 0620-5-1-.03, continued)

	(waived if admitted)	emergency (waived if admitted); $10 copay per use for non-emergency
Chiropractic Care	$15 copay; Maintenance visits not covered when no additional progress is apparent or expected to occur	$5 copay; Maintenance visits not covered when no additional progress is apparent or expected to occur
Ambulance Service – Air & Ground	No copay 100% of reasonable charges when deemed medically necessary by claims administrator	No copay 100% of reasonable charges when deemed medically necessary by claims administrator
Lab and X-ray	No copay 100% benefit	No copay 100% benefit
Physical, Speech & Occupational Therapy	$15 copay per visit; Limited to 52 visits per year per condition	$5 copay per visit; Limited to 52 visits per year per condition
Mental Health Inpatient (preauthorization required)	$100 copay per admission; Limited to 30 days per year	$5 copay per admission; Limited to 30 days per year
Substance Abuse Inpatient (preauthorization required)	$100 copay per admission; Limited to two 5-day detox stays per lifetime; plus one 28-day lifetime stay	$5 copay per admission; Limited to two 5-day detox stays per lifetime; plus one 28-day lifetime stay
Mental Health/Substance Abuse Outpatient (preauthorization required)	$20 copay per session; Limited to 52 sessions mental health and substance abuse combined	$5 copay per session; Limited to 52 sessions mental health and substance abuse combined
Annual Out-of-Pocket Maximums	5% of family income	5% of family income

(Rule 0620-5-1-.03, continued)

No co-payments will be charged for well-child visits, immunizations, or lab and x-ray services. There is also no co-payment for ambulance services when deemed medically necessary by the health plan. For children in families with income at or below 150 percent of the Federal Poverty Limit, co-payments will not exceed $5.00, except the co-payment for non-emergency use of the emergency room will be $10.

(b) For enrollees with family income equal to or under 250% of the Federal Poverty Limit, the aggregate cost sharing for a family shall not exceed 5% of the family's annual income.

(c) As required by Federal law, American Indian and Alaska Native children as defined by the Indian Health Care Improvement Act of 1976 will be exempt from all cost sharing.

(d) A family that does not pay a required co-payment remains enrolled in the program. An individual provider may at his or her discretion refuse service for non-payment of a co-payment unless a medical emergency exists. The state does not participate in collection action or impose any benefit limitations if enrollees do not pay co-payments.

(4) All cost sharing provisions of these rules are subject to changes in Federal laws, regulations, and binding legal directives from the Federal government.

Authority: *T.C.A. §§ 4-5-202, 71-3-1106. 71-3-1110.* ***Administrative History:*** *Public necessity rule filed March 13, 2007; expired August 25, 2007. Original rule filed May 30, 2007; effective August 13, 2007. Amendments filed May 22, 2008; effective August 5, 2008.*

0620-5-1-.04 DISENROLLMENT.

(1) Grounds for Disenrollment from CoverKids.

(a) Children enrolled in CoverKids at or below 250% of the FPL are financially eligible for 12 months, except in the following situations, which will result in disenrollment from CoverKids coverage prior to the end of the 12 month period.

1. An enrollee, through an authorized family member, requests disenrollment.

2. Admission of a CoverKids enrollee into a correctional facility or an institution for mental disease.

3. A CoverKids enrollee moves from the state.

4. Death of a CoverKids enrollee.

5. A CoverKids enrollee is enrolled in TennCare.

6. A CoverKids enrollee meets a TennCare Medicaid spend-down.

7. A CoverKids enrollee turns age 19.

8. A woman 19 or older who was enrolled because of pregnancy is no longer eligible after the last day of the month in which the sixtieth post-partum day occurs.

(Rule 0620-5-1-.04, continued)

9. A CoverKids enrollee gains access to state-sponsored health insurance through a family member's employment with a state or local education agency that has state sponsored health insurance or contributed to state sponsored health insurance as defined in 42 C.F.R. 457.301.

10. A CoverKids enrollee is enrolled into individual, group or employer-based coverage.

11. A CoverKids enrollee is discovered not to have been eligible for CoverKids at the time of enrollment. This includes, but is not limited to, enrollees whose enrollment was obtained by fraud or misrepresentations by an enrollee, parent, guardian, or representative.

(b) A child above 250% of the Federal poverty level, as defined in these rules and under Federal law, may be disenrolled for nonpayment of premiums, as described more fully in regulation 0620-5-1-.03, as well as the reasons set forth in subparagraph (1)(a).

(2) Procedures.

(a) Disenrollments shall be conducted under the procedures set forth in section 0620-5-1-.05 of these rules.

Authority: *T.C.A. §§ 4-5-202, 71-3-1106. 71-3-1110.* ***Administrative History:*** *Public necessity rule filed March 13, 2007; expired August 25, 2007. Original rule filed May 30, 2007; effective August 13, 2007. Repeal and new rule filed May 22, 2008; effective August 5, 2008.*

0620-5-1-.05 ADMINISTRATIVE REVIEW OF COVERKIDS DECISIONS.

(1) Eligibility and Enrollment Matters. The parent of an enrollee or applicant may obtain review of a denial of eligibility, suspension or termination of enrollment (including termination for failure to pay premiums or cost sharing), or a situation in which eligibility decisions have not been made in a timely manner, through the following procedures.

(a) Informal Review.

1. A parent will be notified of a denial of eligibility or suspension or termination of enrollment in writing, and such notice will contain the reason for the denial, the procedures for seeking review of this decision, and the anticipated time by which review will be completed. Parents may also request a review for situations in which eligibility determination have not been made in a timely manner. Parents will be notified that termination or suspension of enrollment will not be effective until the completion of the review process provided in these rules.

2. Parents may request review by sending a written request to the Administrative Contractor (AC) or calling the eligibility and enrollment AC's toll-free number. This request for review must be received by the AC within 30 days of issuance of written notice of the action for which review is requested or, if notice is not provided, 30 days from the time the applicant becomes aware of the action.. They may report additional information or clarify information on the applicant's account. The AC will document the call and any additional information/clarification provided. AC eligibility staff will review the matter.

(Rule 0620-5-1-.05, continued)

3. If the AC's review does not result in the child being eligible, the parent will be notified of the reason the denial was upheld. The notification letter will inform the parent that they may submit a formal request in writing to the Division of Insurance Administration, to be reviewed by the state-level CoverKids Eligibility Appeals Committee.

(b) Formal Review.

1. The parent may request a formal review of the informal review decision with a parent may request a formal review of the informal review decision with a written request to the Division of Insurance Administration. This request must be received by the Division within 30 days of issuance of the informal review decision. Receipts of requests for review will be acknowledged in writing within 10 days, including notification that a decision should be issued within one calendar month of receipt of the acknowledgment letter.

2. The Eligibility Appeals Committee, composed of five Division of Insurance Administration staff members, will review eligibility and enrollment matters. The members of this committee shall not have been directly involved in the matter under review. If the Committee disagrees with the decision of the AC, the child will be enrolled in CoverKids. If at any level of dispute, the appropriate party determines the child is eligible for enrollment in CoverKids, the enrollment will become effective retroactive to the first day of the month following the initial eligibility determination.

3. Parents may represent themselves or have a representative of their choosing in connection with formal reviews. Parents may review information relevant to the review of the decision in a timely manner and may submit supplemental information during the review process. Enrollees will remain enrolled pending completion of the review in the case of suspension or termination of enrollment.

4. The Committee is not required to conduct in-person hearings or to conduct a contested case under the requirements of the Uniform Administrative Procedures Act.

5. If the Committee agrees with the decision to deny eligibility, a letter will be sent to the parent detailing the reason for denial. The decision of the Eligibility Appeals Committee will be the final administrative recourse available.

(c) Deadlines for Review.

1. Expedited review will be provided if an applicant provides a statement from a medical professional that she or he has a medical situation that is life threatening or would seriously jeopardize the enrollee's health or ability to attain, maintain or regain maximum functioning. Expedited review should be completed within 10 days of receipt of the request.

2. All enrollment or eligibility matters not subject to expedited review shall be determined within a reasonable time.

(Rule 0620-5-1-.05, continued)

(2) Health Services Matters. A parent of a CoverKids enrollee may request review of a Cover Kids action to delay, deny, reduce, suspend, or terminate health services, or a failure to approve, furnish, or provide payment for health services in a timely manner, according to the following provisions.

(a) Notice. Any decision denying, or delaying a requested health service, reducing, suspending, or terminating an existing health service, or failure to approve, furnish, or provide payment for health services in a timely manner shall be in writing and must contain the reason for the determination, an explanation of review rights and procedures, the standard and expedited time frames for review, the manner of requesting a review, and the circumstances under which existing health services may continue pending review unless there is question that the existing health services are harmful.

(b) Contractor Review. Parents commence the review process by submitting a written request to the Plan Administrator (PA) within 30 days of issuance of written notice of the action or, if no notice is provided, from the time the enrollee becomes aware of the action not to exceed six (6) months from when the action occurred. The PA will review this request and issue a written decision within 30 days of receipt of this request. Expedited reviews (within 72 hours) will be available for situations in which a benefit determination or a preauthorization denial has been made prior to services being received and the attending medical professional determines in writing (including legible handwriting) the medical situation to be life threatening or would seriously jeopardize the enrollee's health or ability to attain, maintain or regain maximum functioning. This determination should be made in legible writing with an original signature.

(c) State Informal Review. After the PA's internal review is completed, the parent of an enrollee who disagrees with the decision may request further review by submitting a letter or form to the State Division of Insurance Administration which must be received within 8 days of the Administrator's decision. The Appeals Coordinator within the Division will review the matter and gather supplemental information from the family, physician, and/or insurer as needed. The Appeals Coordinator may also request review by the state's independent medical consultant. A written decision of the Appeals Coordinator should be issued within 20 days of receipt of the request for further review.

(d) State Review Committee. If the informal review does not grant the relief requested by the parent, the request will be scheduled for review by the CoverKids Review Committee. The Committee will be composed of five members, including Division of Insurance Administration staff and at least one licensed medical professional, selected by the Commissioner or his designee. The members of the Committee will not have been directly involved in the matter under review. The parent will be given the opportunity to review the file, be represented by a representative of the parent's choice, and provide supplemental information. The Committee may allow the parent to appear in person if it finds that scheduling the appearance will not cause delay in the review process. The Review Committee is not required to provide an in-person hearing or a contested case under the Uniform Administrative Procedures Act. The parent will receive written notification of the final decision stating the reasons for the decision. The decision of the CoverKids Review Committee is the final administrative recourse available to the member.

(e) Time for Reviews. Review of all non-expedited health services appeals will be completed within 90 days of receipt of the initial request for review by the PA.

(Rule 0620-5-1-.05, continued)

Reviews by both the Appeals Coordinator and the Committee may be expedited (completed within 72 hours at each the PA and State levels) for situations in which a benefit determination or a preauthorization denial has been made prior to services being received and the attending medical professional determines in writing (including legible handwriting) that the medical situation to be life threatening or would seriously jeopardize the enrollee's health or ability to attain, maintain or regain maximum functioning.

(3) Scope of Review. CoverKids will not provide a review process for a change in enrollment, eligibility, or coverage under the health benefits package required by a change in the State plan or Federal and State law requiring an automatic change that affects all or a group of applicants or enrollees without regard to their individual circumstances.

Authority: *T.C.A. §§ 4-5-202, 71-3-1106. 71-3-1110.* ***Administrative History:*** *Public necessity rule filed March 13, 2007; expired August 25, 2007. Original rule filed May 30, 2007; effective August 13, 2007.*